Completion of Patient Care Report

This policy provides clarification on the completion time of the Patient Care Report (PCR) via the emsCharts application.

➢ A patient care report must be generated anytime a dispatch number is assigned by the Communications Center. (If you are dispatched to a call and you are cancelled prior to leaving the base you may ask the Communication Center to simply cancel the dispatch number.)

➢ All patient care reports must be entered during the duty shift of the employee rendering care to the patient. In addition, the patient care report must be locked within twenty-four (24) hours of the call being completed.

     o It is recognized that in some cases, employees have patient care reports to do after the end of their duty shift; furthermore it is recognized that employees must be sufficiently rested at the beginning of their next consecutive duty shift. It is acceptable to leave a patient care report incomplete and finish it at the beginning of the next duty shift in the following conditions:

         ▪ The employee has worked two hours past the end of his/her duty shift either running calls or inputting patient care reports and is scheduled to work the next day/night.

         ▪ ALS calls or any call that may need to be reviewed by a physician, nurse, medical examiner, or other persons who will be involved in the patient's care after EMS care MUST be completely documented before the employee goes home.

         ▪ If the employee wishes to leave any call undocumented he/she must call the on-duty Shift Supervisor. The employee will advise the supervisor how many calls will be undocumented and give a brief description of the calls. The supervisor can choose to give or deny permission to leave patient care reports incomplete based on the type of calls the employee describes.

         ▪ If an employee is scheduled to be off the next day/night, he/she will complete ALL patient care report for the current shift regardless of how long they may have to work over.

➢ Only employees of Catawba County EMS will complete a patient care report.

➢ During times when the Internet is not accessible or the emsCharts web site cannot be accessed, personnel shall not delay inputting the chart. The "emsCharts Mobile" application is to be utilized instead.

     o As soon as the Internet or emsCharts website is functional the crew member that entered the chart will upload the emsCharts Mobile record.

- o Once the record(s) is uploaded, the employee will then sign in to the on-line version of emsCharts and complete the chart if necessary. If the chart is completed prior to upload, the employee needs only to electronically sign the chart and complete / lock the chart.

- o If an employee enters a chart in emsCharts Mobile and is unable to upload it prior to the end of their shift, that employee is responsible for notifying the on-duty Shift Supervisor that the record has not been uploaded.

➢ The following represents the minimal documentation required for any call in which there is patient contact.

- o Dispatch Information (Page 1 -- Patient Information)

- o Patient / Bystander Interview (Page 2 – History of Present Illness)

- o Chief Complaint (Page 2 – System, Symptom, Impression, Chief Complaint)

- o History of the Present Illness / Mechanism of Injury (Page 2 – History of Present Illness)

- o Primary Assessment (Page 3 / Page 4)

  - ▪ Level of Consciousness (Page 3)

  - ▪ Airway (Page 3)

  - ▪ Breathing (Page 4)

  - ▪ Circulation (Page 4)

- o Identification of Life Threatening Situations (Page 2 – Impression)

- o Secondary Assessment (Focused Exam -- Page 5)

  - ▪ Include information that is pertinent to the Chief Complaint, History of the Present Illness, or Mechanism of Injury. (Page 5)

- o Additional Assessment (ECG, 12-Lead ECG, SPO_2, Blood Glucose, etc…) (Page 8 – Activity Log)

- o Treatment (include overall treatment regimen and specific information) (Page 8 – Activity Log: an addendum may be used if necessary)

- o Intravenous Access (include specific information if performed) (Page 8 – Activity Log)
- o Intubations (include specific information if performed) (Page 8 – Activity Log)
- o Chest Decompression (include specific information if performed) (Page 8 – Activity Log)

- o Needle / Surgical Cricothyrotomy (include specific information if performed) (Page 8 – Activity Log)

- o Medication Administration (include specific information if performed) (Page 8 – Activity Log)

- o Response to any treatment or medication (Page 8 – Activity Log)

- o Reassessment information (Page 8 – Activity Log)

- o Location transported to (Page 1 – Patient Information)

- o Receiving staff member information (Page 1 – Patient Information)

- o Orders approved (if applicable) (Page 8 – Activity Log)

- o LP 12 data must be imported into the chart anytime a patient is attached to the monitor

- o Documentation associated with the chart (i.e., Signature Sheet, Medical Necessity Form, etc…) must be scanned and attached to the chart

Since there is no narrative field in emsCharts, additional information may be added to the Chief Complaint, Secondary Complaint, History of Present Illness, and Scene Description fields. In addition, each vital sign and action entry has a comment box that can be used for additional information. An addendum may also be added to the chart if more space is needed for additional information.